

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6431	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Michael		MIDDLE		LAST Silvers		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR 7 30 1979	
3. SEX male	4. RACE black	5. DATE OF BIRTH MONTH DAY YEAR 4 30 60		6. AGE (IN YEARS) LAST BIRTHDAY 19 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 30 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 325 McMechen St.					
14. FATHER'S NAME FIRST MIDDLE LAST Vernon Silver				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celesta Cooper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-84-7630		17. INFORMANT Celesta Silver		ADDRESS 325 McMechen St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 7 9102										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30 AM 7/29 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) fell in water fishing from pier							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Pier		21f. LOCATION STREET CITY OR TOWN COUNTY Cox Point/820 Riverside Drive, Back River, MD Balto. County							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE H. R. Shand		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER				DATE SIGNED 7/30/79			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/3/79		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR AUG 02 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

1810

1810

1810

1810

1810

X

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 6 4 3 2		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Maximillian Josef SIMMETH				July 14, 1979		2:45am			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS	
Male		White		July 14, 1979		YRS MONTHS DAYS		HOURS MINS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Franklin Square Hospital		None		None			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Harford		Bel Air		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2103 W. Court (Mothers address)	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Josef Maximillian Simmeth		Patricia Ann Shuman		No				Mother-Patricia Simmeth 2103 W. Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7651		Immaturity		Prematurity					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/14/79, 19 79, to 7/14, 19 79, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 7/14, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
S. Fingerhood, M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		7/14/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Shelly Fingerhood, M.D.		9000 Franklin Square Drive, Balto, Md 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Released to Hosp.		7/14/79		Franklin Square Hosp.		Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NONE				JUL 26 1979		Anthony McCreedy			

5 2 2 5



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 7/76

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. 16433	
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST		2b. DATE KNOWN OF DEATH	
ALVIN MORLEY SIMON								7/22 1979	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD
Male	White	Oct 10, 1929		49 YRS.					19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pittsburgh, Pa.		USA				Baltimore County, Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Reisterstown, Md		Camp Milldale				Manager		Scrap Metal Yard	
13a. STATE				13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS
Maryland				Baltimore	Randallstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3925 Chaffey Road 21133
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Late Louis Simon				Late Elizabeth Briskman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes				W. W. 11 Army 210-14-4740		Mrs. Rena Simon- 3925 Chaffey Rd 21133			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									minutes
410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b) <u>Arteriosclerotic C.V. Disease</u>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Martin E. Strobel</u>				TITLE (SPECIFY) Deputy				DATE SIGNED 7-23-79	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS					
Martin E. Strobel, M.D.				59 Hanover Road, Reisterstown,					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				July 24/79		Forband-Lazer Rissa Sklar Road		Md.	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Sol. Levinson & Bros. Inc. 6010 Reisterstown						JUL 26 1979		<u>Robert K. K...</u>	

MEDICAL CERTIFICATION

68-01-87



FILED

DAVID

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Health and Mental Hygiene Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 1 6 4 3 4							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BESSIE</b> <b>SINGER</b> <b>SINGER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 11 1979</b>		2b. HOUR MIN <b>10:15</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>UNOBTAINABLE</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>89</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> XXX DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>PIKESVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PIKESVILLE NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3225 SOUTHGREEN RD. #21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM</b> <b>GROSSMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA</b> <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>214-74-8836</b>		17. INFORMANT ADDRESS <b>MIKE REICH 3225 SOUTHGREEN RD. #21207</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetic mellitus</b> Approximate interval between onset and death: <b>2500</b> years <b>15 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Heated serum, repaired - Carboxia</b>									
19a. DATE OF OPERATION <b>7-13-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>August 19, 52</b> to <b>July 11, 1979</b> , that (I) (we) lost the deceased alive on <b>7/10</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two died) (I did not) view the body after death.									
22b. SIGNATURE <b>Joseph C. Matchon M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH C. MATCHER, M.D.</b>				22e. ADDRESS <b>3635 OLD COURT RD. #21208</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7-13-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TIFEREETH ISRAEL ANSHE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>STARD ROSEDALE BALTO. MD</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 16 1979</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
6010 REISTERSTOWN RD. BALTO., MD 21215									



P. 6. C.

25412





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 6 4 3 5 REG. NO.		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur Slade		2a. DATE OF DEATH MONTH DAY YEAR July 4, 1979		2b. HOUR 8:10a M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 27 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk		12b. KIND OF BUSINESS OR INDUSTRY Corcoran's	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Overlea									
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Kopp		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-8291		17. INFORMANT ADDRESS Marie E. Slade 104 E. Elm Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest 4409 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardio-Respiratory Failure (c) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis; Pneumonia; Chronic Obstructive Pulmonary Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Benign Prostatic Hyperplasia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 13, 19 79, to July 4, 19 79, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 4, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE Dr. Arwindeker				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED July 4, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Arwindeker				22e. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/7/79		23c. NAME OF CEMETERY OR CREMATORY St. Michael Leth.		23d. LOCATION CITY OR TOWN COUNTY STATE Perry Hall Baltimore Md.			
24. FUNERAL DIRECTOR NAME Lassahn F.H.				ADDRESS 7401 Belair Rd.		25a. DATE REC'D. BY REGISTRAR JUL 9 1979			

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.DHMH - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR Items 19b. & 22a. 1 - STATE REGISTRAR #535 9/24/79 dad					7 9 1 6 4 3 6 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD J. SMITH					2a. DATE OF DEATH MONTH DAY YEAR JULY 31, 1979			2b. HOUR 9:25 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 11, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.				
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY G.M.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Smith					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT ADDRESS Mrs. Helen A. Bauer 2635 Matthews Drive						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4809 IMMEDIATE CAUSE (a) Extensive bilateral pneumonia, possibly viral DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION 7/31/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Transbronchial biopsy				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 25, 19 79, to July 31, 19 79, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 31, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did (did not) view the body after death. natural										
22b. SIGNATURE H. S. Crist, M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED August 1, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry S. Crist, M.D.				22e. ADDRESS 7620 York Road, Towson, MD 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto., Md.				
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR AUG 6 1979						

0 8 4 8 0

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.

1000

Year	Month	Day	Time	Place	Remarks
1900	Jan	1	10:00	Washington	Arrived
1900	Jan	2	10:00	Washington	Left
1900	Jan	3	10:00	Washington	Arrived
1900	Jan	4	10:00	Washington	Left
1900	Jan	5	10:00	Washington	Arrived
1900	Jan	6	10:00	Washington	Left
1900	Jan	7	10:00	Washington	Arrived
1900	Jan	8	10:00	Washington	Left
1900	Jan	9	10:00	Washington	Arrived
1900	Jan	10	10:00	Washington	Left

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 6 4 3 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Kenneth Emanuel SMITH					2a. DATE OF DEATH MONTH DAY YEAR July 12, 1979					2b. HOUR 10:45 AM
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 4 24		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13c. STREET ADDRESS 816 Cedar Avenue
13a. STATE Md.		13b. COUNTY Essex		13c. CITY OR TOWN						
14. FATHER'S NAME FIRST MIDDLE LAST Irvin Smith					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Marva Smith		ADDRESS 816 Cedar Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) Acute bile peritonitis superimposed on hepatic decompensation, secondary to portal cirrhosis DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 4, 19 79, to July 12, 19 79, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 12, 19 79, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.										
22b. SIGNATURE F. Shukairy, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 7/12/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fayez Shukairy MD		22e. ADDRESS 9000 Franklin Square Dr, 21237								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/17/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.				
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 17 1979		25b. REGISTRAR'S SIGNATURE Bridget McBrady		

MEDICAL CERTIFICATION

BP

10-1-31

(14)

Financial Statement

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

10-1-31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 6 4 3 8 REG. NO. 12:15PM									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
BABY      BOY      SPELLMAN					7-22-79					6:45 PM	
3. SEX MALE		4. RACE Negro		5. DATE OF BIRTH 7-22-79		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY		MONTHS		DAYS	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT JOSEPH HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4416 La Plata Ave.			
14. FATHER'S NAME FIRST      MIDDLE      LAST Clinton      Spellman					15. MOTHER'S MAIDEN NAME FIRST      MIDDLE      LAST Trina      Spellman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY - ARREST.</u> <u>7798</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>SEVERE IMMATURITY.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30-45 min.</u> <u>20-25 min.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>SEVERE IMMATURITY</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M.      MONTH      DAY      YEAR P.M.      19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET      CITY OR TOWN      COUNTY      STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7-22-79</u> , to <u>7-22-79</u> , that <input checked="" type="checkbox"/> (we) lost <u>7-22-79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE <u>Richard M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>7-22-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PORNSWAN</u> <u>WASANT</u>				22e. ADDRESS <u>ST. JOSEPH HOSPITAL.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Released to Hosp</u>		23b. DATE <u>July 22, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Hospital</u>		23d. LOCATION CITY OR TOWN      COUNTY      STATE <u>Towson</u> <u>Balto.</u> <u>MD</u>					
24. FUNERAL DIRECTOR NAME <u>Sam [unclear]</u>				ADDRESS <u>7620 York Rd., Towson, MD</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 30 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



88.01

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



10/10/1973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 4 3 9

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH - MONTH DAY YEAR			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles T. Sprinkel			July 17, 1979			3 A. M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1931	6. AGE (IN YEARS LAST BIRTHDAY) 48			7. UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Owings Mills			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Owings Mills			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3005 Walnut Ave.			12a. BALTIMORE CITY OR COUNTY OF DEATH Baltimore		
12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Bendix Corp.			12c. KIND OF BUSINESS OR INDUSTRY			12d. MD.		
13a. STATE Md.			13b. COUNTY Balto.			13c. CITY OR TOWN Owings Mills		
13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3005 Walnut Ave.			13f. MD.		
14. FATHER'S NAME FIRST MIDDLE LAST John W. Sprinkel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Younger			16. ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-26-7801			17. INFORMANT Mrs. Ingrid G. Sprinkel		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary arrest</u> 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last: (b) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 ps</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT SCHOOL <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 73</u> to <u>7/17 79</u> , that (I) (we) last saw the deceased alive on <u>5/25 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not visit the body after death.			22b. SIGNATURE <u>Morton Elin Kellin</u> DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-17-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton Elin Kellin			22e. ADDRESS 5310 Old Court Road Randallstown, Maryland 21133			22f. MD.		
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE July 20, 79			23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md.			23e. DATE REC'D. BY REGISTRAR JUL 18 1979			23f. REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u>		
24. FUNERAL DIRECTOR Eline Funeral Home			24b. ADDRESS Reisterstown, Md. 21136			24c. DATE REC'D. BY REGISTRAR JUL 18 1979		

1000

John	W.	Swedish	1900	1900	1900	1900	1900	1900	1900
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife
Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife	Wife

Handwritten notes and signatures in the center of the page, including a large signature that appears to read "John W. Swedish".

Printed text at the bottom of the page, including "John W. Swedish" and "1900".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 4 4 0	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Stacharowski, Adam</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>7 13 79</i>		2b. HOUR <i>4:12</i> M			
3. SEX <i>Male</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 - 24 - 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MAJOR CARE ROSSVILLE</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Maintenance</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Rosedale</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>5906 Hamiltun Ave.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Stacharowski</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-10-8259</i>		17. INFORMANT ADDRESS <i>Wanda Stacharowski 5906 Hamiltun Ave.</i>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of stomach</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) <i>-</i> DUE TO, OR AS A CONSEQUENCE OF c) <i>-</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>ASCVD, status post subtotal gastrectomy</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from <i>6/30/78</i> to <i>7/13/79</i> , that <i>X</i> (we) last saw the deceased alive on <i>4pm 7/13/79</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>						DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/13/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>K. M. TUN</i>						22e. ADDRESS <i>2110 Pot Spring Road Balto Md 21093</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>7/16/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Balto. MD.</i>			
24. FUNERAL DIRECTOR NAME <i>W. A. Coach</i>				ADDRESS <i>1211 Chesaw Ave.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

0 1 6 1 8 1

25

70-25-11

0 1 6 1 8 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Paul O. Standen</b> 2a. DATE OF DEATH MONTH <b>July</b> DAY <b>28</b> YEAR <b>1979</b> 2b. HOUR <b>7:20 P.</b> 3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH MONTH <b>6</b> DAY <b>27</b> YEAR <b>1906</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Co. Md.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD. 10. CITY OR TOWN OF DEATH <b>Reisterstown</b> 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>233 Northway Rd</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Tool &amp; Dye</b> USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Reisterstown</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>233 Northway Road</b> 14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE LAST 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>468-10-6043</b> 17. INFORMANT ADDRESS <b>233 Northway Rd. Mrs. Florence M. Standon, Reisterstown, Md.</b> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBROVASCULAR ACCIDENT</b> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1 HOUR</b> <b>5 YEARS</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CEREBROVASCULAR ACCIDENT</b> 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 22, 1979</b> , to <b>JULY 28, 1979</b> , that (I) (we) last saw the deceased alive on <b>JULY 22, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. 22b. SIGNATURE <b>Anthony A. Lewandowski</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <b>07-29-79</b> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTHONY A LEWANDOWSKI M.D.</b> 22e. ADDRESS <b>300 E Joppa Rd. Towson Md 21204</b> 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b> 23b. DATE <b>7/29/79</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Security Processing</b> 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b></b> STATE <b>Md.</b> 24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home, 11824 Reisterstown Rd.</b> ADDRESS <b>Reisterstown, Md</b> 25a. DATE REC'D. BY REGISTRAR <b>AUG 2 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Anthony A. Lewandowski</b>									







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 16442	
FOR 1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD F. STANFIELD</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JULY 24, 1979</b>			2b. HOUR <b>9 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 10, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hospit.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dairy Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Phletus Stanfield</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Emma Fite</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT <b>Mrs. Marjorie Stanfield</b>		17b. ADDRESS <b>9000 Church Rd. Randallstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> <b>496-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>July 24, 1979</b> , to <b>July 24, 1979</b> , that (I) (we) last saw the deceased alive on <b>July 24, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Bernardo D. Gonzalez Jr.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>7/24/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARDO D. GONZALEZ JR.</b>					22e. ADDRESS <b>BALTO. COUNTY GEN. HOSP.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olive Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Balto. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Coring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, Md. 21133</b>						DATE REC'D. BY REGISTRAR <b>JUL 26 1979</b>		REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>			

3 1 0 1 1 1 3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#8, Film G535 9/5/79 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roger Henry STEMLER			2a. DATE OF DEATH MONTH DAY YEAR 7 30 79		2b. HOUR a 11:55 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 20 27		
6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Frederick Stemler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Holley		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 214-20-9486		17. INFORMANT Catherine S. Lowe		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest &amp; Congestive heart failure</u> 4275- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS: 215 Pinewood Rd. Balto. MD 21222		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/22/79</u> , 19 <u>79</u> , to <u>7/30</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Stephen O. Bookbinder</u>		DEGREE M.D.		22c. DATE SIGNED 7/30/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Bookbinder, M.D.		22e. ADDRESS 9000 Franklin Square Drive				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 8/2/79		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem.		
23d. LOCATION CITY OR TOWN COUNTY STATE White Marsh, Balto. MD						
24. FUNERAL DIRECTOR NAME ADDRESS Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD		25a. DATE REC'D. BY REGISTRAR AUG 02 1979		25b. REGISTRAR'S SIGNATURE <u>Patricia McBrady</u>		

BP \_\_\_\_\_

6 1 1 0 1 1 1 1

(M)

1

2

3

4

5

6

7

8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					7 9 1 6 4 4 4				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
JOSEPH Martin Stepanek					7/20/79				
3 SEX					2b. HOUR				
Male					10:05 aM				
4 RACE					5. DATE OF BIRTH				
Cauc.					1/31/98				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					6. AGE (IN YEARS LAST BIRTHDAY)				
Maryland					81 YRS.				
7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
USA					9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Towson					Coin Opr.				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12b. KIND OF BUSINESS OR INDUSTRY				
Greater Baltimore Medical Center					Banking				
13a. STATE					13b. COUNTY				
Md.					Balto.				
13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?				
Cockeysville					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Albert Stepanek					Annie Moravec				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
Yes					WW II				
17. INFORMANT					ADDRESS				
Mrs. Anna W. Weil					1517 Applecroft Ln.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Arteriosclerotic cardiovascular disease with renal failure</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7/18</u> , 19 <u>79</u> , to <u>7/20</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
<i>Rudiger Breiteneker</i>					7/20/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Rudiger Breiteneker, M.D.					6701 N. Charles St., Balto., MD 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
Burial					7/23/79				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN COUNTY STATE				
Holy Redeemer Cem.					Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
J. E. Lowell Lemmon, 10 W. Padonia Rd.					JUL 26 1979				

BP

AP. 01 - 91





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 6 4 4 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Emma E. Stroemer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>July 30, 1979</b>				2b. HOUR <b>8:25 AM</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 16, 1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Cty., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>House in the Pines - Fusting Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b> 13c. COUNTY <b>---</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2606 Marbourne Avenue</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Dressel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Resch</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-50-2481</b>		17. INFORMANT <b>Baltimore, Md. 21230. Martin L. Stroemer-2606 Marbourne Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1002</b> <b>20 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>June 14, 1979</b> to <b>July 30, 1979</b> that (I) (we) last saw the deceased alive on <b>July 28, 1979</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.								
22b. SIGNATURE <b>William K. Bollinger, Sr. M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-30-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William K. Bollinger, Sr. M.D.</b>		22e. ADDRESS <b>609 Frederick Ave. Balt. Md. 21228</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/31/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Stirling Funeral Estab.</b>		ADDRESS <b>736 Edmondson Ave. Catonsville Md 21033</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>		





July 20, 1929

Dear Sir

W.

Dear Sir

July 20, 1929

W.

Dear Sir

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

Baltimore County

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 1 6 4 4 6	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ira W. Strauss</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>July 19, 1979</b>			2b. HOUR <b>8:30 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 9, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Summit Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Baltimore City Emp. - Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>AA</b>		13c. CITY OR TOWN <b>Pasadena</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1515 Long Point Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Strauss</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>N/A</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-36-6551</b>		17. INFORMANT ADDRESS <b>Miss Kathryn Dougherty - Neice</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4392 Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS EVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Diabetes mellitus, Peripheral Vascular Disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>1/6/79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/6/79</b> 19 to <b>7/19/79</b> 19, that (I) (we) last saw the deceased alive on <b>7/19/79</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James E. Rowe M.D.</b>					22c. DATE SIGNED <b>20 July 79</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James Rowe, M. D.</b>					22e. ADDRESS <b>413 Commonwealth Ave., Catonsville</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>23 July 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>James S. Kirkley, Glen Burnie, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 24 1979</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Properly completed and signed, this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 4 4 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>PAULINE R. STROTT</b>						2a. DATE OF DEATH MONTH <b>07</b> DAY <b>28</b> YEAR <b>79</b>				2b. HOUR <b>5:45 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>08</b> YEAR <b>01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.							
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FOREST HAVEN NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>WOODLAWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2609 PURNELL DRIVE, 21207</b>					
14. FATHER'S NAME FIRST <b>AUGUST</b> MIDDLE <b>ROTH</b> LAST <b>ROTH</b>				15. MOTHER'S MAIDEN NAME FIRST <b>ANNA</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>213-74-3239</b>		17. INFORMANT ADDRESS <b>BURNETT E. STROTT, 2609 PURNELL DRIVE</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE CEREBRAL INFARCTS</b> <b>4349</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>2 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>NONE</b>													
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 19 <b>76</b> , to <b>JULY 28</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7-22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Leon Ashman</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7-29-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEON ASHMAN, M.D.</b>						22e. ADDRESS <b>5907 GWYNN OAK AVENUE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>07-31-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>							
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>						ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara K. Brady</b>			

7 4 0 1 9 7

UNITED STATES  
DEPARTMENT OF THE ARMY  
WASHINGTON, D. C.

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

12-1-42

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				7 9 1 6 4 4 8	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE M. STUDLEY			2a. DATE OF DEATH MONTH DAY YEAR 7-10-79		2b. HOUR 10-45AM
3. SEX F	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 7, 1892	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CO. MD.		
10. CITY OR TOWN OF DEATH RANDALLSTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. CO. GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.			13b. COUNTY BALTO.	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS H. BRIGHT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA BOGGS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-20-7088	17. INFORMANT ADDRESS JAMES C. FIFER 3553 GAMBER RD. 21048		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest to 496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COPD & kyphoskoliosis, and ASCVD E (c) CHF, Anemia I DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-6-1979, to 7-10-1979, that (I) (we) last saw the deceased alive on 7-10-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R.M. SHAT			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-10-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAT			22e. ADDRESS Baltimore County General Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-13-79	23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		23d. LOCATION CITY OR TOWN BALTO. CO. MD.	STATE
24. FUNERAL DIRECTOR NAME Frank H. Newell, Inc. Pikesville, Md			25a. DATE REC'D. BY REGISTRAR JUL 16 1979		25b. REGISTRAR'S SIGNATURE P. J. McCreedy

BP

8 4 2 1 1 1



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 4 4 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Emma Bell Stultz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 25, 1979</b>			2b. HOUR <b>5A.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 18, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Balto. County</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3413 Liberty Gardens Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto. County</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3413 Liberty Gardens</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christian G. Wike</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma H. Otts</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INDEMNITY ADDRESS <b>Mr. Roger B. Stultz</b>				21207 <b>3413 Liberty Gardens Rd. Balto. Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-20</b> , 19 <b>77</b> , to <b>7-25-79</b> , 19 <b>79</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>7-16</b> , 19 <b>79</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> (did not) view the body after death.										
22b. SIGNATURE <b>Abraham B. Hurwitz M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>7-26-79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Abram Hurwitz</b>					22e. ADDRESS <b>7501 LIBERTY ROAD, BALTIMORE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/27/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Md.</b>				
24. FUNERAL DIRECTOR'S NAME <b>Goring Byers Funeral Directors, P.A.</b>					25. DATE REC'D. BY REGISTRAR <b>7/30/79</b>					
8728 Liberty Road Randallstown, Md. 21133					25b. REGISTRAR'S SIGNATURE					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

9 4 . 2 1 4 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 6 4 5 0		REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
Emilie Gustine STUMPFEL						July 26, 1979				4:25 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		White		May 10, 1893		86		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rossville		Franklin Square Hospital				Domestic		Private		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Balto.		Overlea		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		628 Dale Ave. 21206		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
Unknown				UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		21206		
No		217.01.5673		Albert M. Stumpf		626 Dale Ave,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest, Aspiration</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Senility, Organic Brain Syndrome</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Arteriosclerotic Cardiovascular Disease</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (this hospital) attended the deceased from <u>July 17, 1979</u> to <u>July 26, 1979</u> , that (we) lost saw the deceased alive on <u>July 26, 1979</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.										
22b. SIGNATURE				DEGREE				22c. DATE SIGNED		
Clarke B Andrews M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				July 26, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
Clarke B. Andrews M.D.				9000 Franklin Square Drive 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE
Cremation		7/27/1979		Loudon Park		Baltimore				Md.
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Walter Brooks Bradley Inc				Dundalk Md.		JUL 30 1979		Dorothy McCreedy		

0.2

001 26 0000000000



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 4 5 1

1. DECEASED NAME (TYPE OR PRINT) <b>Ida Roberts Sturtz</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>July 6, 1979</b>		2b. HOUR MIN. <b>10:15 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH DAY MONTH YEAR <b>FEB. 20, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rosedale</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>409 Patapsco Avenue</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Rosedale</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emil Wockenfuss</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie Schwartz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>21225134</b>		17. INFORMANT ADDRESS <b>Audrey E. Erdman 409 Patapsco Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <b>Unstable Angina</b> DOE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>59</b> , to <b>May</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (did) (did not) view the body after death.)					
23a. SIGNATURE <b>John G. Orth, M.D.</b>		DEGREE		23c. DATE SIGNED <b>7/7/79</b>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN G. ORTH</b>		23d. ADDRESS <b>8019 PHILADELPHIA RD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		23e. DATE RECEIVED BY REGISTRAR <b>JUL 11 1979</b>		23f. REGISTRAR'S SIGNATURE <b>Robert J. McCreedy</b>	
24. FUNERAL DIRECTOR NAME <b>1211 Chesaco Ave.</b>		25. DATE RECEIVED BY REGISTRAR <b>JUL 11 1979</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 4 5 2	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Clifford Edwin Sullivan</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 23, 1979</b>		2b. HOUR <b>M</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 22, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Carroll Co.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.					
10. CITY OR TOWN OF DEATH <b>Reisterstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14201 Old Hanover Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired St. Road Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Reisterstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>14201 Old Hanover Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John P. Sullivan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Stibbs</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 1 220-34-5973</b>		17. INFORMANT ADDRESS <b>Mrs. Lillian E. Sullivan Reisterstown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6 cardiac arrest</b> <b>436-</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>6 I R D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION <b>7-23-79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>none</b>							
21d. INJURY OCCURRED WHERE <input checked="" type="checkbox"/> HOME <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Reisterstown Md</b>							
22a. I certify that (1) (this hospital) attended the deceased from <b>Sept 1-1-48</b> to <b>7-23-79</b> , that (1) (we) last saw the deceased alive on <b>Sept 1-1-48</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James G. Saffell</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>7-24-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James G. Saffell</b>				22e. ADDRESS <b>64 M 2nd St Reisterstown Md 21136</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) <b>Burial</b>		23b. DATE <b>July 26, 79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Gilead Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Reisterstown, Md.</b>					
24. FUNERAL DIRECTOR <b>Elaine Funeral Home Reisterstown, Md. 21136</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 27 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lillian E. Sullivan</b>			

BP



100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 6 4 5 3		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Agnes Swain						July 29 79				10-30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONTH DAY YEAR		83 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Randallstown		Baltimore County Gen. Hospit.				Housewife					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		Reisterstown		<input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		21136 119 Sunnyking Drive	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Unknown				Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		none		219-01-9008D		Mr. Arnold Swain 119 Sunnyking Drive 21136					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M.		19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29/1979</u> to <u>7/29/1979</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>7/29/1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
<u>Swain</u>						7/29/79.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
SRINIVAS.		Baltimore County general hospital.				BALTIMORE MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		8/1/79		Loudon Park Cemetery Baltimore, Md.							
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Loring Byers Funeral Directors						JUL 31 1979		<u>John H. Brady</u>			
8728 Liberty Road Randallstown, Md. 21133											

BP \_\_\_\_\_

10102

10102



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 16454

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DAVID W. SWAN SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7-14-79</b>			2b. HOUR M				
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-27-16</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Edgemere</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2308 RUTH AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY		13c. CITY OR TOWN <b>Edgemere</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2308 Ruth Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Swan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-01-0456</b>		17. INFORMANT ADDRESS <b>Lillian E. Swan 2308 Ruth Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Esophageal Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Silicosis</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 10</b> , 19 <b>79</b> , to <b>JULY 10</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>JULY 10</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Debra Wertheimer MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>7/15/79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DEBRA WERTHEIMER</b>					22e. ADDRESS <b>BALTO. CITY HOSPITALS</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/17/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arbutus, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H</b>					ADDRESS <b>1101 E. North Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 17 1979</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

A. C. P. O. L. S. V.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16455	
1. DECEASED NAME (TYPE OR PRINT) <i>Calvin Spurgeon Tardy</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7-13 1979		2b. HOUR 7:00 PM			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 15, 1925</i>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <i>54</i>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>19</i>		2d. HOUR <i>M</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Army</i>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto. Co.</i>		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>3724 Coronado Rd. 21207</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lloyd S. Tardy</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sadie Madline Foster</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWI &amp; Korea</i>		17. INFORMANT ADDRESS <i>Mrs. Akiko Tardy</i> <i>3724 Coronado Rd. Balto. Md. 21207</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d) <i>Arteriosclerotic Vascular Disease</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Conrado Ferrero</i>		TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER		DATE SIGNED <i>7-13-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Dr. Conrado Ferrero</i>		ADDRESS <i>5550 Balto Wtr. Pike</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/16/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Pikesville, Md.</i>					
24. FUNERAL DIRECTOR'S NAME <i>Doring Byers Funeral Directors, P.A.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 18 1979</i>		25b. REGISTRAR'S SIGNATURE <i>John A. Brady</i>					
ADDRESS <i>8728 Liberty Road Randallstown, Md. 21133</i>											

2001

RECEIVED

...







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 4 5 6

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
BABY BOY TEAGUE - TEAGUE		7-10-79		5:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	CAUCASIAN	7-10-79	2 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
BALTO.	U.S.A.		BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTO.	ST. JOSEPH HOSP.				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD	Harford	Hickory	21028		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		1900 Conowingo Rd., Hickory, MD	
TIM TEAGUE		FLORA BROOKS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
NO			FATHER		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). IMMATURE (SEVERE) IMMATURE (SEVERE) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7798 DUE TO, OR AS A CONSEQUENCE OF: (b) CARDIO-RESPIRATORY FAILURE CARDIO-RESPIRATORY FAILURE (c) DUE TO, OR AS A CONSEQUENCE OF: (c) IMMATURE (SEVERE) IMMATURE (SEVERE) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE KNOWN					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
21g. I certify that (this hospital) attended the deceased from 7-10-79, 19, to 7-10-79, 19, that (we) last saw the deceased alive on 7-10-79, 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (not) view the body after death.		22a. SIGNATURE P. Warrant MD.		22b. DATE SIGNED 7-10-79.	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) PIRNSWAN WASANT MD		22d. ADDRESS ST-JOSEPH HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Released to Hosp.		23b. DATE July 10, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Hospital	
24. FUNERAL DIRECTOR NAME Samuel R.		24b. ADDRESS 7620 York Rd., Towson, MD		25a. DATE REC'D. BY REGISTRAR JUL 13 1979	
				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

BP



INVESTIGATION (20-100)

CARD - BERTHOLDY RALPH

CHIEF

20% CO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Add. Info. Film G533 7/10/79 kam				STATE OF MARYLAND			
FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF DEATH				7 9 1 6 4 5 7			
1- DECEASED NAME				REG. NO.			
FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR			
Erwin Tepper				July 7, 1979			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		April 7, 1909		70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Germany		U.S.A.				Baltimore County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rossville		Franklin Square Hospital		Retired		Bethlehem Steel	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Theodor Tepper				Natalie Geliert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		213-07-1255		Mr. Erwin T. Tepper, Jr. 9518 Dawnvale Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis							
5770							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from July 5, 1979, to July 7, 1979, that (I) (we) lost the deceased alive on July 7, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE				DEGREE		22c. DATE SIGNED	
M. KHAN						7/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
M. KHAN				9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7-11-1979		Parkwood		Baltimore Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. 5305 Harford Rd. Balto, Md.				JUL 9 1979		[Signature]	

1601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 16458

1. DECEASED NAME (TYPE OR PRINT) <b>Eugene Thomas SR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 10, 1979</b>			2b. HOUR <b>8:45</b>		
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 28, 1938</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>51</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>HAMPTON, VA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY</b>		
10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POTTER CANST.</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a STATE <b>MARYLAND</b>		13b COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2740 HARLEM AVE</b>
14 FATHER'S NAME <b>PHILMORE</b>				15. MOTHER'S MAIDEN NAME <b>KATIE REED</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>220-22-6804</b>		17 INFORMANT <b>LILLIE B. THOMAS</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION <b>May 21, 1979</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>711 W. 40th St.</b>		CITY OR TOWN <b>BALTO.</b>		COUNTY <b>MARYLAND</b>
22a. I certify that (I) (this hospital) attended the deceased from <b>May 28, 1978</b> to <b>July 10, 1979</b> , that (I) (we) lost saw the deceased alive on <b>July 10, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Marshall A. Levine</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/10/79</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marshall A. Levine</b>				22e. ADDRESS <b>711 W. 40th St. Balto, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTHNOT MEMORIAL</b>		23d. LOCATION CITY OR TOWN <b>ARBUTHNOT, MARYLAND</b>		
24 FUNERAL DIRECTOR NAME <b>LEROY O. DYETT &amp; SON</b>				ADDRESS <b>4600 LIB. HIGTS.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 12 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lester K. ...</b>







FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC NO 6459

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
WADE		THOMAS		THOMPSON		JR		7		27		1979	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Male	White	July 10, 1924		55 YRS.						7		27 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				BALTIMORE							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Randallstown		BALTO. Co. Gen. Hospital		Engineer #4		Co. Gov't.							
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Md.		CARROLL		Woodbine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6010 Woodbine Rd.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
WADE T.		Thompson, Sr.		No		218 14 6100		MARY E. Thompson		Woodbine, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4292		ASCVD + HYPERTENSION				YEARS							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF									
		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		P.M. T9											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED							
E. P. Williams II		Deputy				7-27-79							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
E. P. Williams II		5550 BALTO. NAIL PIKE											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		7-31-79		Lake View Cemetery		Lynchville		CARROLL		MD			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Harry W. Knight		Lynchville, Md.		AUG 3 1979		L. J. McCready							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IN EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 6 4 6 0 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
PERRY Basil TILLER								7 18 79		2:20A <sub>M</sub>	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		8 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
Male		White		Dec. 23, 1914		64					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				BALTIMORE COUNTY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		GBMC-6701 N. CHARLES ST.				Welder		St. Equipment			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Harford		Abingdon				4 Valiant Drive			
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Walter -- Tiller				Ruth -- Ball							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
no				227-05-3246		Mrs. Trula Hein, Fallston, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 } DUE TO, OR AS A CONSEQUENCE OF CA OF LUNG											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF											
(c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6-9 19 79 to 7-18 19 79, that (I) (we) last saw the deceased alive on 7-18 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
								7-18-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
LUIS POLLACCHI, M.D.						GBMC-6701 N. CHARLES ST.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		July 20, 1979		Harford Mem. Gardens		Aldino		Harford Md.			
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas III, Abingdon, Md.						JUL 23 1979		Pietro McCroskey			

BP

100-100000

100-100000

BALTIMORE COUNTY

100-100000

100-100000

RESPIRATORY TRACT

CA OF LUNG

100-100000

100-100000

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 7/77  
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 16461 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA ELIZABETH TIPPETT							2a. DATE OF DEATH MONTH DAY YEAR 7 20 79		2b. HOUR 9:30 PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 19 30		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. FUNERAL 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.								
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SPRING GROVE STATE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRACTICAL NURSE		12b. KIND OF BUSINESS OR INDUSTRY NURSING						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND							13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS SPRING GROVE STATE HOSPITAL	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY R. TERRIE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-30-9864		17. INFORMANT ADDRESS JONES-ASH FUNERAL HOME, HEATHSVILLE, VA.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 DUE TO, OR AS A CONSEQUENCE OF (b) EMPHYSEMA (c) ANEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH OVER 2 months 2 months + 2 months +				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (1) ASCITES (2) CHRONIC SCHIZOPHRENIA (3) HEART DISEASE														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from June 12, 1979, to July 20, 1979, that (I) (we) last saw the deceased alive on 7-20-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE MUN-KI KIM, MD						DEGREE MD			22c. DATE SIGNED 7-20-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MUN-KI KIM, MD						22e. ADDRESS Spring Grove State Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 07-23-79		23c. NAME OF CEMETERY OR CREMATORY WARSAW CHURCH OF GOD			23d. LOCATION CITY OR TOWN COUNTY STATE WARSAW RICHMOND VA.						
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.				ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE Lillian McBratney						

10.01.01

10.01.01

EMMA

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

10.01.01

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16462

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Alma	MIDDLE M	LAST Torbit	2e. DATE KNOWN OF DEATH ESTIMATED		MONTH JULY	DAY 14	YEAR 1979	2f. HOUR 2P			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 4	DAY 3	YEAR 01	6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YRS.	IF UNDER 1 YR. MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH JULY	DAY 14	YEAR 1979	2d. HOUR 2P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD							
10. CITY OR TOWN OF DEATH Lutherville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 Tenbury Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Homemaking			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11 Tenbury Road					
14. FATHER'S NAME FIRST William				MIDDLE		LAST Fuller		15. MOTHER'S MAIDEN NAME FIRST Letitia		MIDDLE		LAST McCormick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-52-7004		17. INFORMANT ADDRESS Harold F. Torbit 11 Tenbury Road									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sanitized ASCVD</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>with Senile Dementia</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5+ yrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE SIGNED 7/14/79			
EXAMINER'S NAME (TYPE OR PRINT) Charles F. O'Donnell				ADDRESS 7501 York Road											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/17/79		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION CITY OR TOWN Parkville Baltimore Md.					
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				ADDRESS 7401 Belair Road				25a. DATE REC'D. BY REGISTRAR JUL 20 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McCarty</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

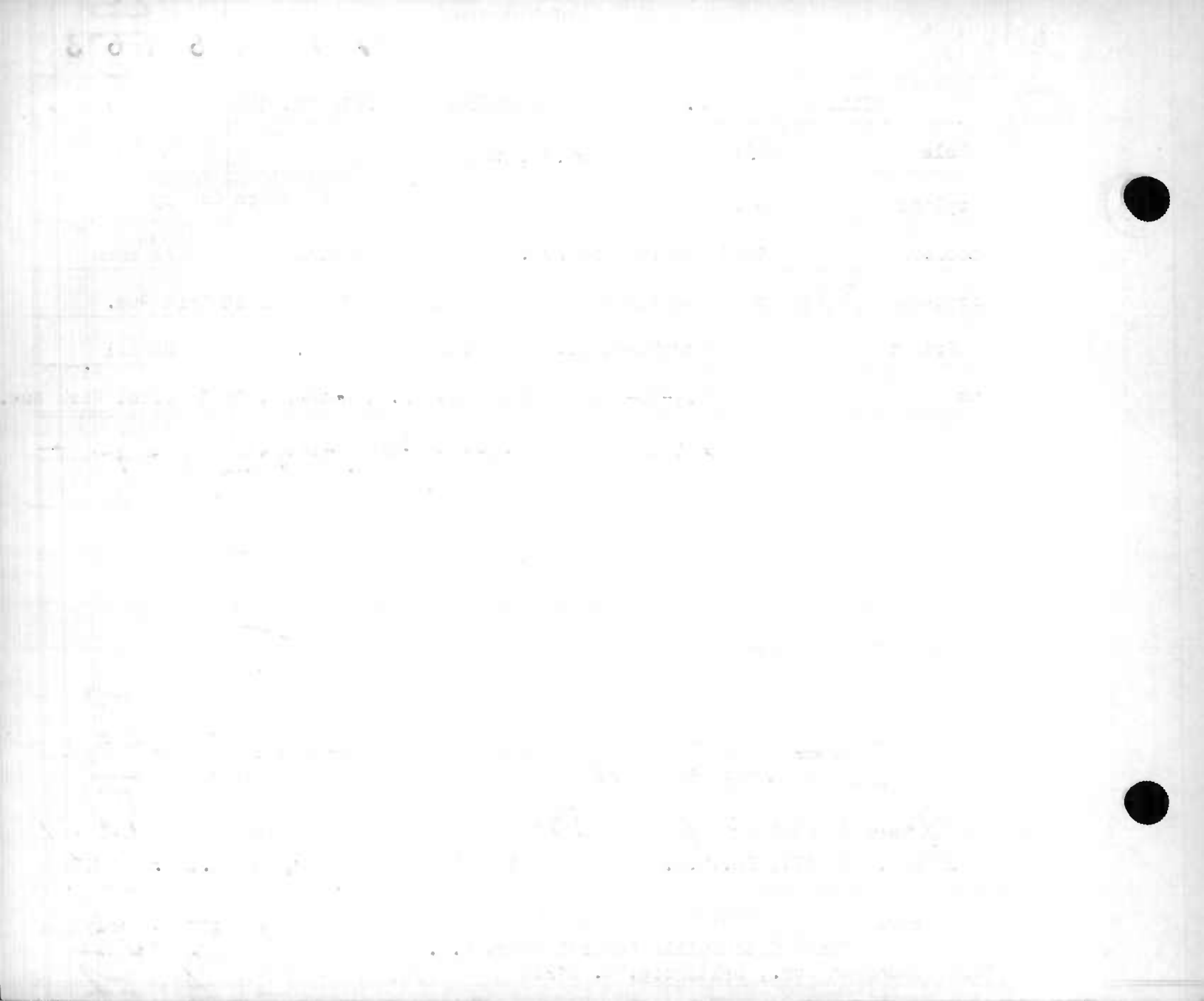
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 20M  
(VRA 15, 4) 7/78

M

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 4 6 3	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM D. TOWNSHEND</b>			2a. DATE OF DEATH <b>July 12, 1979</b>			2b. HOUR <b>1:30 P.M.</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 14, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>1661 Forest Park Ave.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Woodlawn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1661 Forest Park Ave.</b>		
14. FATHER'S NAME <b>Arthur</b>			15. MOTHER'S MAIDEN NAME <b>Susan O. Hemill</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>287-09-9026</b>			17. INFORMANT <b>Miss Helen E. Townshend, 1661 Forest Park Ave.</b>			ADDRESS <b>21207</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular vascular disease</b> <b>429.2</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs +</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) (us) attended the deceased from <b>1951</b> 19____, to <b>July 12</b> 19 <b>79</b> , that (I) (we) (us) last saw the deceased alive on <b>July 2</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) (did not) view the body after death.											
22b. SIGNATURE <b>John A. Nesbitt, Jr., M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>7-13-79</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <b>1009 Frederick Road, Balto., Md. 21228</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/15/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oakland, Garrett, Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Witzke Catonsville Funeral Home, P.A.</b>						24b. DATE REC'D. BY REGISTRAR <b>JUL 16 1979</b>		24c. REGISTRAR'S SIGNATURE <b>John A. Nesbitt, Jr.</b>			
24a. FUNERAL HOME NAME <b>1630 Edmondson Ave., Baltimore, Md. 21228</b>											

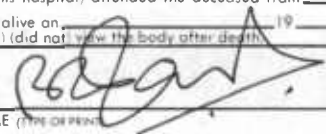



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 4 6 4

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert Poole TREADWELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 31, 1979</b>			2b. HOUR <b>5:15AM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 30, 1908</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1667 Mussula Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Adjuster</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21204</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1667 Mussula Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert L. Treadwell</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie I. Poole</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>914-03-1230</b>		17. INFORMANT ADDRESS <b>M. Elizabeth Treadwell Towson, Md. 21204</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell left broncheal CA involving</b> <b>1622</b> DUE TO, OR AS A CONSEQUENCE OF <b>carina.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/31/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.D. Parekh, M.D.</b>					22e. ADDRESS <b>1131 Belair Road Bleair, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Aug. 1, '79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>William E. Johnson 8521 Loch Raven Blvd</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 31 1979</b>		25b. REGISTRAR'S SIGNATURE 			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 6 4 6 5													
FOR 1 - STATE REGISTRAR			REG. NO.																				
1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH		DAY		YEAR		2b HOUR			
Charlotte Hill Turner												7-12-79								9 <sup>35</sup> P.M.			
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.								
Female			White			6-19-1909			70			MONTHS			DAYS			HOURS			MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH														
Ohio			Usa						Baltimore County MD.														
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Catonsville			Shangri-La Nursing Center										Secretary			Board of Ed							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET ADDRESS								
Md						Ellicott City			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6063 Waterloo Road											
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME																				
FIRST			MIDDLE			LAST			FIRST			MIDDLE			LAST								
Morey						Hill			Jane						Staifer								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			6063 Waterloo Road														
no			308-14-8586			James H. Turner			Ellicott City, Maryland			21043											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Metastatic Breast Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Primary site unknown</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a I certify that (I) (this hospital) attended the deceased from <u>June 15</u> 19 <u>79</u> to <u>12 July</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12 July</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED														
<u>William J. Bryson</u>			MD						<u>13 July 79</u>														
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS																				
William Bryson																							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN			COUNTY			STATE								
burial			7/16/79			Meadowridge Mem. Park			Elkridge, Howard, Maryland														
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE														
SLACK Funeral Home, Ellicott City, Maryland			21043			JUL 16 1979			<u>[Signature]</u>														

BP \_\_\_\_\_

000111



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16466

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST JAMES			MIDDLE Rudolph			LAST VALENTINE			2a. DATE KNOWN OF DEATH ESTI- MATED			<input checked="" type="checkbox"/> MONTH 7 7 19 79			2b. HOUR M 12:35 a M					
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 5 1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR 7 7 19 79			2d. HOUR a M					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD											
10. CITY OR TOWN OF DEATH Dundalk				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Searles Rd.								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer				12b. KIND OF BUSINESS OR INDUSTRY Beth Steel							
13a. STATE Florida				13b. COUNTY Hialeah				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS St. Andrews Drive											
14. FATHER'S NAME FIRST MIDDLE LAST Walter Valentine				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tear				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No								16b. SOCIAL SECURITY NO. 215-05-0602				17. INFORMANT 204 Addison St. Marlene McKnight Fayetteville, N.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 7-7-79											
EXAMINER'S NAME (TYPE OR PRINT)				Ann M. Dixon, M.D.								ADDRESS 111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/10/79				23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland											
24. FUNERAL DIRECTOR NAME 7922 Wise Avenue				ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR JUL 10 1979				25b. REGISTRAR'S SIGNATURE R. H. H. H.											



0 0 0 0 0 0 0 0 0 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 16467

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) LUCIE Amanda VERRILLI		MONTH DAY YEAR JULY 4, 1979		12:15AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE County MD.		10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTO. MEDICAL CENTER	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept. of Def.		12b. KIND OF BUSINESS OR INDUSTRY Civil Serv.		13a. STREET ADDRESS 961 Central Lane	
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Gambrills	
14. FATHER'S NAME FIRST MIDDLE LAST William A. Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Davis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 216.44.8951		17. INFORMANT ADDRESS 223 Glen Road		Mr. Joseph Verrilli (son) Glen Burnie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1629 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC CA. OF LUNG					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that X (this hospital) attended the deceased from JUNE 12, 1979, to JULY 4, 1979, that X (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (do not) view the body after death.		22b. SIGNATURE P. J. Patel	
22c. DATE SIGNED JULY 4, 1979		22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. J. PATEL		22e. ADDRESS 6701 NORTH CHARLES STREET 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 7, 79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland		24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, Md.		25. DATE REC'D. BY REGISTRAR JUL 5 1979	
25b. REGISTRAR'S SIGNATURE P. J. Patel					



6-1-01  
JULY 4, 1979 12:15PM  
Lucie Amanda Verilli  
White  
Female  
Baltimore, Md.  
Baltimore County  
TOMSON  
GREATER BALTO. MEDICAL CENTER DEPT. OF GEN. INT'L MED.  
STYLISH  
REMBOLD  
X  
1981 Central Line  
Wesley  
X  
X  
CARDIORESPIRATORY ARREST

METASTATIC CA. OF LUNG

6701 NORTH CHARLES STREET 21204  
P. J. PATEL  
JULY 7, 1979  
X  
JUNE 12 79  
X  
JULY 4 79  
X  
JULY 4, 1979  
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. Page 74 should be retained by the funeral director. Page 75 should be retained by the funeral director. Page 76 should be retained by the funeral director. Page 77 should be retained by the funeral director. Page 78 should be retained by the funeral director. Page 79 should be retained by the funeral director. Page 80 should be retained by the funeral director. Page 81 should be retained by the funeral director. Page 82 should be retained by the funeral director. Page 83 should be retained by the funeral director. Page 84 should be retained by the funeral director. Page 85 should be retained by the funeral director. Page 86 should be retained by the funeral director. Page 87 should be retained by the funeral director. Page 88 should be retained by the funeral director. Page 89 should be retained by the funeral director. Page 90 should be retained by the funeral director. Page 91 should be retained by the funeral director. Page 92 should be retained by the funeral director. Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		7 9 1 6 4 6 8		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <u>Olivia Beulah Vordemberge</u>				2a DATE OF DEATH MONTH DAY YEAR <u>7-13-79</u>		2b HOUR <u>3:30 PM</u>			
3 SEX <u>Female</u>		4 RACE <u>Caucasian</u>		5 DATE OF BIRTH MONTH DAY YEAR <u>Jan 10, 1905</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>74</u>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County, Md.</u> MD.			
10 CITY OR TOWN OF DEATH <u>Towson</u>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Multi-Medical Conv. Center</u>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u>				13b COUNTY <u>Baltimore</u>		13c CITY OR TOWN <u>Catonsville</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <u>Noah Jones</u>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Anna Dewalt</u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b SOCIAL SECURITY NO. <u>214-74-3373</u>		17 INFORMANT ADDRESS <u>Mr. Herman L. Vordemberge Same as 13</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4439 DUE TO OR AS A CONSEQUENCE OF (b) <u>Sepsis + Hypotension</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Perforated viscus and gangrene</u> 2-3 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Dehydration, malnutrition, hypofunction</u>									
19a DATE OF OPERATION <u>N/A</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>N/A</u>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>N/A</u>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> <u>N/A</u>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f LOCATION STREET <u>N/A</u>		CITY OR TOWN <u>N/A</u>		COUNTY <u>N/A</u>	
22a I certify that (I) (this hospital) attended the deceased from <u>6/13/79</u> to <u>7/13/79</u> , that (I) (we) last saw the deceased alive on <u>7/11/79</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If "yes" is marked, I did not view the body after death.)									
22b SIGNATURE <u>A. H. Ganoski, MD</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>7/13/79</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. H. GANOSKI, MD</u>				22e ADDRESS <u>22 So Green ST Balt Md 21201</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b DATE <u>7/16/79</u>		23c NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d LOCATION CITY OR TOWN <u>Baltimore City, Md.</u>		COUNTY <u>Baltimore</u>	
24 FUNERAL DIRECTOR NAME <u>MacNabb Funeral Home</u>				ADDRESS <u>Catonsville, Md.</u>		25a DATE REC'D. BY REGISTRAR <u>JUL 16 1979</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Marie Anna Waldron			July 28, 1979			8:50AM		
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Female	Cau.	9 23 96	82 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.	U.S.A.		Baltimore County, MD.					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Balto.	Franklin Square Hosp.		U.S. Govt.			Retired		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d INSIDE CITY LIMITS?			13e STREET ADDRESS		
13a STATE	13b COUNTY	13c CITY OR TOWN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1828 Willann Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
John J. Pratt			Anna Marie Hora					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO	17 INFORMANT ADDRESS					
no		578-16-4603	Mr. John J. Pratt 1828 Willann Rd.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 410 - IMMEDIATE CAUSE (a) Left Cerebrovascular Accident, Status Post Two Myocardial Infarctions, Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Status Post Pacemaker, Atrial Fibrillation, Congestive Heart Failure								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from July 21, 1979, to July 28, 1979, that (I) (we) last saw the deceased alive on July 28, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE			DEGREE			22c DATE SIGNED		
Meher F. Tabatabai			M.D.			7/28/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS					
Meher Tabatabai, M.D.			9000 Franklin Square Drive 21237					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		
Burial		7-31-79		Balto. Cem.		Balto. - Md.		
24 FUNERAL DIRECTOR NAME				25a DATE RECEIVED BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
John C. Miller Inc. 6415 Belair Rd.				AUG 1 1979		[Signature]		

BP

100101-1

UNITED STATES  
NAVY



[Faint, mostly illegible text spanning the main body of the page, possibly a memorandum or report.]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 16470

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE KNOWN OF DEATH		22. DATE KNOWN OF DEATH		23. DATE KNOWN OF DEATH		24. DATE KNOWN OF DEATH		25. DATE KNOWN OF DEATH		26. DATE KNOWN OF DEATH		27. DATE KNOWN OF DEATH		28. DATE KNOWN OF DEATH		29. DATE KNOWN OF DEATH		30. DATE KNOWN OF DEATH		31. DATE KNOWN OF DEATH		32. DATE KNOWN OF DEATH		33. DATE KNOWN OF DEATH		34. DATE KNOWN OF DEATH		35. DATE KNOWN OF DEATH		36. DATE KNOWN OF DEATH		37. DATE KNOWN OF DEATH		38. DATE KNOWN OF DEATH		39. DATE KNOWN OF DEATH		40. DATE KNOWN OF DEATH		41. DATE KNOWN OF DEATH		42. DATE KNOWN OF DEATH		43. DATE KNOWN OF DEATH		44. DATE KNOWN OF DEATH		45. DATE KNOWN OF DEATH		46. DATE KNOWN OF DEATH		47. DATE KNOWN OF DEATH		48. DATE KNOWN OF DEATH		49. DATE KNOWN OF DEATH		50. DATE KNOWN OF DEATH		51. DATE KNOWN OF DEATH		52. DATE KNOWN OF DEATH		53. DATE KNOWN OF DEATH		54. DATE KNOWN OF DEATH		55. DATE KNOWN OF DEATH		56. DATE KNOWN OF DEATH		57. DATE KNOWN OF DEATH		58. DATE KNOWN OF DEATH		59. DATE KNOWN OF DEATH		60. DATE KNOWN OF DEATH		61. DATE KNOWN OF DEATH		62. DATE KNOWN OF DEATH		63. DATE KNOWN OF DEATH		64. DATE KNOWN OF DEATH		65. DATE KNOWN OF DEATH		66. DATE KNOWN OF DEATH		67. DATE KNOWN OF DEATH		68. DATE KNOWN OF DEATH		69. DATE KNOWN OF DEATH		70. DATE KNOWN OF DEATH		71. DATE KNOWN OF DEATH		72. DATE KNOWN OF DEATH		73. DATE KNOWN OF DEATH		74. DATE KNOWN OF DEATH		75. DATE KNOWN OF DEATH		76. DATE KNOWN OF DEATH		77. DATE KNOWN OF DEATH		78. DATE KNOWN OF DEATH		79. DATE KNOWN OF DEATH		80. DATE KNOWN OF DEATH		81. DATE KNOWN OF DEATH		82. DATE KNOWN OF DEATH		83. DATE KNOWN OF DEATH		84. DATE KNOWN OF DEATH		85. DATE KNOWN OF DEATH		86. DATE KNOWN OF DEATH		87. DATE KNOWN OF DEATH		88. DATE KNOWN OF DEATH		89. DATE KNOWN OF DEATH		90. DATE KNOWN OF DEATH		91. DATE KNOWN OF DEATH		92. DATE KNOWN OF DEATH		93. DATE KNOWN OF DEATH		94. DATE KNOWN OF DEATH		95. DATE KNOWN OF DEATH		96. DATE KNOWN OF DEATH		97. DATE KNOWN OF DEATH		98. DATE KNOWN OF DEATH		99. DATE KNOWN OF DEATH		100. DATE KNOWN OF DEATH																			
1. DECEASED NAME (TYPE OR PRINT)		2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS)		6. IF UNDER 1 YR.		7. IF UNDER 24 HRS.		8. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED		13. NEVER MARRIED		14. WIDOWED		15. DIVORCED		16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		19. KIND OF BUSINESS OR INDUSTRY		20. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		21. CITY OR TOWN		22. INSIDE CITY LIMITS?		23. STREET ADDRESS		24. FATHER'S NAME		25. MOTHER'S MAIDEN NAME		26. WAS DECEASED EVER IN U.S. ARMED FORCES?		27. SOCIAL SECURITY NO.		28. INFORMANT		29. ADDRESS		30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		31. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		32. PART I DEATH WAS CAUSED BY:		33. IMMEDIATE CAUSE (a)		34. DUE TO, OR AS A CONSEQUENCE OF		35. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		36. (b)		37. DUE TO, OR AS A CONSEQUENCE OF		38. (c)		39. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		40. DATE OF OPERATION		41. CONDITION FOR WHICH OPERATION WAS PERFORMED?		42. AUTOPSY?		43. YES		44. NO		45. 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		46. 21b. TIME OF INJURY		47. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		48. 21d. INJURY OCCURRED		49. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		50. 21f. LOCATION		51. CITY OR TOWN		52. COUNTY		53. STATE		54. 22a. I certify that I took charge of the remains described above, held on death resulted from		55. Autopsy <input checked="" type="checkbox"/>		56. Inspection <input type="checkbox"/>		57. Inquiry <input type="checkbox"/>		58. and in my opinion		59. death resulted from		60. Natural causes <input type="checkbox"/>		61. Accident <input checked="" type="checkbox"/>		62. Suicide <input type="checkbox"/>		63. Homicide <input type="checkbox"/>		64. Undetermined manner <input type="checkbox"/>		65. TITLE (SPECIFY)		66. M.D. Deputy Chief		67. MEDICAL EXAMINER		68. DATE SIGNED		69. 7/24/79		70. EXAMINER'S NAME (TYPE OR PRINT)		71. Thomas D. Smith, M.D.		72. ADDRESS		73. 111 Penn St.		74. Balto., MD		75. 23a. BURIAL, CREMATION, REMOVAL		76. 23b. DATE		77. 23c. NAME OF CEMETERY OR CREMATORY		78. 23d. LOCATION		79. CITY OR TOWN		80. COUNTY		81. STATE		82. 24. FUNERAL DIRECTOR		83. NAME		84. Carlton C. Douglass		85. ADDRESS		86. 669-1778		87. 1012 Penn Ave		88. 25a. DATE REC'D. BY REGISTRAR		89. JUL 25 1979		90. 25b. REGISTRAR'S SIGNATURE		91. [Signature]	

0 1 1 0 1 0 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The lower portion of this certificate is to be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The lower portion of this certificate is to be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The lower portion of this certificate is to be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

DHMH - 16 50M 1/76  
(VR A 15 (4))

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 16471	
1. FOR REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Dunaway H. Walker			July 15, 1979			M		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		
Male			White			Sept. 11, 1894			84 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			U.S.A.						Baltimore County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (IF FOR MORE THAN MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Frederick Villa Nursing Center			School Teacher			Balt. City		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland						Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS			13f. BALTIMORE CITY OR COUNTY OF DEATH		
John Harry Walker			Mary Beach Martin			Balt, Md. 21217			2131 Bolton Street		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. DATE OF DEATH			17. INFORMANT			17b. ADDRESS		
Yes			WW I			Guardian: Linda C. Heyman			Balt., Md. 21217		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY:			18b. IMMEDIATE CAUSE (a)			18c. DUE TO, OR AS A CONSEQUENCE OF			18d. DUE TO, OR AS A CONSEQUENCE OF		
1990 Cardio. Pulmonary arrest						Coronary atherosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			Atherosclerosis								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DEGREE			22d. DATE SIGNED					
Dr. Elmo M. Gayoso			M.D.			5411 Old Frederick Road Balt., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			July 18 1979			Woodlawn Cemetery			Baltimore Maryland		
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck, Inc.			Baltimore, Maryland			JUL 17 1979					

MEDICAL CERTIFICATION

BP

I A C I V A

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 1 6 4 7 2  
REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Dorothy S. Wallace</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7 12 79</i>		2b. HOUR <i>7:30 A.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan 19 1925</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3823 Elmcroft Road</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>warehouse</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Randallstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George J. Stein</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hedwig M. Beggeon</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>219-18-9804</i>	
17. INFORMANT <i>Walter R. Wallace</i>		18. ADDRESS <i>3823 Elmcroft Rd. 21207</i>		19. DATE OF OPERATION <i>7/18/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of Breast with metastases</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Breast with metastases</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 Years</i>
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION <i>7/18/79</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer of Breast with metastases</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7:18 7 19 79</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>8204 Liberty Rd. Eldersburg Carroll Md.</i>		22a. I certify that (I) (this hospital) attended the deceased from <i>7/18/79</i> to <i>July 17, 1979</i> , that (I) (we) last saw the deceased alive on <i>7/18/79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Edwin Piepont, MD</i>	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Edwin Piepont M.D.</i>		22b. ADDRESS <i>8204 Liberty Rd.</i>		22c. DATE SIGNED <i>July 13 1979</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/14/79</i>		23c. NAME OF CEMETERY OR REMOVAL PLACE <i>Lakeview Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eldersburg Carroll Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Ambrose Funeral Home, Inc.</i>		ADDRESS <i>1328 Sulphur Sprg. Rd.</i>		25. DATE REC'D. BY REGISTRAR <i>JUL 13 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Robert A. Brady</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5 4 3 2 1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#1, F1mG541 3/4/80 kam FOR STATE REGISTRAR Item 19b. g535 9/24/79 dad		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 1 6 4 7 3 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROXANNE Ann WATSON			2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 7 31 79 635 PM		
3. SEX FEMALE		4. RACE NEGROID		5. DATE OF BIRTH MONTH DAY YEAR 12-2-50	
6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH County MD.			
11. CITY OR TOWN OF DEATH BALTO.		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO. COUNTY GEN.		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3407 POWHATTAN AVE.		14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER WATSON			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERALDINE CARTER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 213-54-3329		17. INFORMANT ADDRESS GERALDINE TABB SAME.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5742 IMMEDIATE CAUSE (a) Massive hemoperitoneum (post cholecystectomy) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Oozing + bleeding from operation sites DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few hrs. Few hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Sickle cell disease (Hb SC), Pulmonary congestion, edema + emphysema.					
19a. DATE OF OPERATION 7/31/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gallstones		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Yuwen Chang, M.D.		DEGREE Pathologist		22c. DATE SIGNED 8/1/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YU-WEN CHANG, M.D.		22e. ADDRESS Baltimore County General Hospital		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-4-79		23c. NAME OF CEMETERY OR CREMATORY King Mem PK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. Md.		24. FUNERAL DIRECTOR NAME ADDRESS VERNON R. BAILEY 1348 CALHOUN ST.			
25a. DATE REC'D BY REGISTRAR AUG 02 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



0 9 1 0 1 0 9

OFFICE OF THE  
DIRECTOR OF THE  
BUREAU OF THE  
CENSUS  
WASHINGTON, D.C.

1910

1. The first of the  
principles of the  
Bureau of the  
Census is that  
the census should  
be taken at  
regular intervals  
of ten years.  
2. The second  
principle is that  
the census should  
be taken in  
the same manner  
and at the same  
time as the  
census of 1900.  
3. The third  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.

4. The fourth  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.  
5. The fifth  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.  
6. The sixth  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.  
7. The seventh  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.  
8. The eighth  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.  
9. The ninth  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.  
10. The tenth  
principle is that  
the census should  
be taken in the  
same manner and  
at the same time  
as the census of  
1900.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 4 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Adyce V. Weaver			2a. DATE OF DEATH MONTH DAY YEAR 7 14 79		2b. HOUR M
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 25 1898		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 84 Shipway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Digman			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Myers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-03-6195		17 INFORMANT ADDRESS Eileen Rosier 84 Shipway Baltimore, 21222	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease (c) Disease DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/6/09 19 to 7/14 79, that (I) (we) lost saw the deceased alive on 4/17/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE THEO. C. PATTERSON, M.D., F.A.C.P. 3427 DUNDALK AVE. DUNDALK, MD. 21222		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/16/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/17/79		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem.	
23d. LOCATION CITY OR TOWN Dorsey, Howard, Maryland		23e. COUNTY Dorsey		23f. STATE Maryland	
24 FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222			25a. DATE REC'D. BY REGISTRAR JUL 17 1979		
25b. REGISTRAR'S SIGNATURE Ruthy McCreedy					

BP

11. 01 11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY F WEBBER			2a. DATE OF DEATH MONTH DAY YEAR 7-30-79			2b. HOUR 11:00 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC 4 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 71			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD.			
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO CO. GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY FOOD	
13a. STATE MD.			13b. COUNTY BALTO.		13c. CITY OR TOWN REISTERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS ? DRISCOLL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY F. HEALY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-10-1225			17. INFORMANT ADDRESS FRANCES SUNDY COLUMBIA, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Cachexia</u> <u>Cancer undetermined origin</u> 2028 DUE TO, OR AS A CONSEQUENCE OF (b) <u>probable gastroenteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Enlarged tract mesenteric nodes</u> <u>Caused due to above</u> <u>Cirrhosis of liver</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years?</u> <u>days</u> <u>Years?</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <u>Anemia due to gastrointestinal bleeding</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE:			
22a. I certify that (I) (this hospital) attended the deceased from 7-29-19 79, to 7-30-19 79, that (I) (we) lost saw the deceased alive on 7-30-19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Quana. Sunel			DEGREE			22c. DATE SIGNED 7-30-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. SUBIEL			22e. ADDRESS BALTIMORE COUNTY GENERAL HOSP.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE Aug 2 1979		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. CO. MD.		
24. FUNERAL DIRECTOR NAME H. J. Eckhardt			ADDRESS Owings Mills, Md.			25a. DATE RECD. BY REGISTRAR			

BP

2716

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7-9 16476	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		REG. NO.	
FIRST MIDDLE LAST Elsa Weilepp		MONTH DAY YEAR 7/21/79		HOUR MIN. 1:45 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8/21/98		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. County MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IN SUCH FACILITY, GIVE STREET ADDRESS) Valley View Nsg. Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN Balto.	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 2715 St. Paul St.	
14. FATHER'S NAME FIRST MIDDLE LAST Adolph A. Weilepp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Lohmeyer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 20 1533		17. INFORMANT ADDRESS Mr. George Ness Balto., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1) Cardiac arrhythmia 4379 DUE TO, OR AS A CONSEQUENCE OF (b) 2) R/o Rupture of Atherosclerotic Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from 2-27 19 79 to 7-21 19 79, that (he) (we) last saw the deceased alive on 7/11/79 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (they) did not view the body after death.)					
22b. SIGNATURE Vuong H. NGUYEN		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/23/79	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS 6 Linlow Ct Towson Md 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-25-79		23c. NAME OF CEMETERY OR CREMATORY Baltimore	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. DATE REC'D. BY REGISTRAR JUL 24 1979		23f. REGISTRAR'S SIGNATURE Henry W. Jenkins	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212		25. DATE REC'D. BY REGISTRAR JUL 24 1979			

0101 1-1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 4 7 7

1. DECEASED NAME (TYPE OR PRINT)			2b. DATE OF DEATH			2c. HOUR		
FIRST MIDDLE LAST CAROLINE V. WELLS			MONTH DAY YEAR 7/12/79			A. M.		
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS
FEMALE	WHITE	MONTH DAY YEAR 08 05 11		67 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.			BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
LANSDOWNE	1005 FREDONIA COURT			SWITCHBOARD OPERATOR		DEPT. STORE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
MARYLAND	BALTIMORE	LANSDOWNE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1005 FREDONIA COURT, 21227				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
WILLIAM C. McKENNA			AMANDA ROBINSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			214-14-1944		WALLACE DANN, 305 W. CHESAPEAKE AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>RECENT MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>WITH VENT TACHYCARDIA</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>CREATING ADVERSE DISSEASE</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/12/79</u> to <u>7/12/79</u> that (I) (we) last saw the deceased alive on <u>7/5/79</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			22b. SIGNATURE <u>ANIL KUMAR FATERPAKER MD</u>			22c. DATE SIGNED <u>7/12/79</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL			07-16-79		BALTIMORE NATIONAL		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC.			4107 WILKENS AVE.		JUL 13 1979		<u>[Signature]</u>	

11101



CHARTERED BY THE

20th CENTURY





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 6 4 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARION O. WELSH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 10, 1979</b>			2b. HOUR <b>3A.</b> M				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 31, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>House in the Pines, Catonsville</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Bendix</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Radio</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>822 Stamford Road 21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Welsh</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Schultz</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>217-01-8642A</b>		17. INFORMANT ADDRESS <b>Mrs. Audrey Pedone, 822 Stamford Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic CVD, advanced</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Urinary Tract infection</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/4</b> 19 <b>78</b> , to <b>7/10</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>7/10</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) (did) (did not) view the body after death.)										
22b. SIGNATURE <b>Herbert J. Levickas, M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>7/10/79</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Herbert J. Levickas</b>						22e. ADDRESS <b>5404 East Drive, Baltimore, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/12/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Witzke Catonsville Funeral Home, P/A, 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby McCreedy</b>		

35  
90  
35  
300  
2  
2  
9  
1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

67.00



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 16479

FOR  
1- STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) VICTORIA		FIRST MIDDLE LAST WHITE		2a DATE OF DEATH MONTH DAY YEAR 7-9-79		2b HOUR 9 <sup>50</sup> PM	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 9-13-99		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BB Building - S.G.H.C.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Md		13b COUNTY BALTO		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 2524 Frederick Ave	
14 FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO 212-14-2188A	
17 INFORMANT ADDRESS WADE Hinton 2524 Frederick Ave		18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD - congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Deambilia - Poss. Septicemia.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-9-79 to July 9, 1979, that (I) (we) last saw the deceased alive on 7-9-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE H. Devadoss		DEGREE H.D. ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 7-9-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Devadoss		22e ADDRESS BB Bldg. - S.G.H.C.					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7-13-79		23c. NAME OF CEMETERY OR CREMATORY MT CALvary CH		23d. LOCATION CITY OR TOWN COUNTY STATE ANN ARUND co. Md	
24 FUNERAL DIRECTOR NAME J. BROWN		ADDRESS 456 N. P.A. 1913 N. BALTO ST		25a. DATE REC'D. BY REGISTRAR JUL 12 1979		25b. REGISTRAR'S SIGNATURE History McNeely	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.

11.01



UNCLASSIFIED  
RECEIVED  
MAY 19 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div>8</div> <div>FOR STATE REGISTRAR</div> <div>7 9 1 6 4 8 0</div> <div>REG. NO.</div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Herman R. Wild</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>July 29, 1979</b>		2b. HOUR <b>9:00A</b>	
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 21 02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>P&amp;BR R.R.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Edgemere</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2215 Lodge Farm Road</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Rudolph Wild</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etta Doebereiner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-10-9426</b>		17 INFORMANT ADDRESS <b>2215 Lodge Farm Road</b> <b>Margaret A. Wild - Balto. MD 21219</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Carcinoma of Prostate</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 6, 19 79</b> , to <b>July 29, 19 79</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>July 29, 19 79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE <b>M. Rajabi, M.D.</b>				DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>7/29/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. Rajabi, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/1/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 30 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Richard A. Brady</i>	

MEDICAL CERTIFICATION



0 0 1 0 0



NOTICE



WED 1 JUL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

16481

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM (NMI) WILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>July 1, 1979</b>			2b. HOUR <b>5:00 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 7, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>15 Treeway Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Will</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ball</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I</b>		17. INFORMANT <b>Mr. Raymond Will</b>		ADDRESS <b>409 Cedarcroft Rd. Baltimore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ileal infarction</b> <b>5608</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fibrous adhesions</b> (c) <b>Intestinal obstruction</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary edema</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/1</b> , 19 <b>79</b> , to <b>7/1</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>7/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. Sirota MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>7/1/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald L. Sirota, M.D.</b>				22e. ADDRESS <b>6701 N. Charles Street, Baltimore MD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>July 4, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immanuel Lutheran Church Baltimore City, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc.</b>				ADDRESS <b>6500 York Rd. Balto., Md.</b>		25a. DAY OF INTERMENT BY REGISTRATION <b>JUL 6 1979</b>			

1810

1810

1810

1810

1810

1810

1810

1810

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 4 8 2

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>BERNICE H. WILSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>7 5 79</b>			2b. HOUR <b>8:10AM</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 12 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. CO.</b>			
10. CITY OR TOWN OF DEATH <b>LUTHERVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>528 MORRIS AVE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CO.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WM. E. HOLBROOK</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CAROLYN HOFFMAN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>217-01-9550</b>			17. INFORMANT NAME ADDRESS <b>JOHN H. WILSON 528 MORRIS AVE.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Respiratory failure.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 76</b> to <b>7/5/79</b> , that (I) (we) last saw the deceased alive on <b>June 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>G. Bedon</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/6/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE BEDON</b>			22e. ADDRESS <b>1205 YORK Rd. Lutherville</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>7-9-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. CO. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>NEWELL F.H.</b>			ADDRESS <b>1100 REISTERSTOWN RD</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History, Maryland</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5 4 3 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 6 4 8 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Harry		Wilson. Sr		7		1		5:55 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		WHITE		08 29 00		78		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. BALTIMORE CITY OR COUNTY OF DEATH	
MD		USA				BALTO CO.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
RANDALSTOWN		BCGH		RETIRED					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS					
Md		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		CARLISLE VALLEY NURSING					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
		ELEANORA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		216-106522		Family		Reed			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)		4292		Upper G.I. Bleeding.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>					
		DO NOT WRITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK							

08101

SECTION 4-179  
STATION 10+00 TO 10+100  
DISTANCE 100.00







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR									
REG. NO. 9 1 6 4 8 4									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice Lenora WINPIGLER						2a. DATE OF DEATH MONTH DAY YEAR July 23, 1979		2b. HOUR 2:43a.m.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10/9/11		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSEW		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9 CRAFTON RD.	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BOOKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HOUSER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216 32 9952		17. INFORMANT ADDRESS MAURICE WINPIGLER ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>to Acute Inferior Lateral Myocardial Infarction</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension, Arteriosclerotic Cardiovascular Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>July 22</u> , 19 <u>79</u> , to <u>July 23</u> , 19 <u>79</u> , that (we) lost saw the deceased alive on <u>July 23</u> , 19 <u>79</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.									
22b. SIGNATURE Jim A. Buck				DEGREE M.D.				22c. DATE SIGNED 7-23-79	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Jim A. Buck M.D.				22c. ADDRESS 9000 Franklin Square Drive 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 7/26/79		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME CONNELLY F.H.				ADDRESS 300 MACE AVE		25a. DATE RECEIVED BY REGISTRAR JUL 26 1979		25b. REGISTRAR'S SIGNATURE	

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810

1810



1810

1810

1810

1810

1810

1810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR		7 9		1 6 4 8 5		REG. NO.						
1. DECEASED NAME (TYPE)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
Michael J. Wolf								7/12/79		930 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
male		white		9 4 13		65 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZENSHIP OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Ind		USA				Baltimore Co. MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF HOME IN WHICH FAMILY GAVE STREET ADDRESS)										
PARKVILLE		3024 Arizona Ave										
12a. USUAL OCCUPATION (TYPE IN WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
U.S. Customs Inspector												
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Ind		Baltimore		PARKVILLE		3024 Arizona Ave						
14. FATHER'S NAME		15. MOTHER'S NAME										
Michael J. Wolf		Elizabeth Hessler										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS								
NO				Stephanie Wolf 3024 Arizona								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Metastatic Ca Prostate Origin												
185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Cachexia												
(c) DUE TO, OR AS A CONSEQUENCE OF Associated Arteriosclerotic Cardiovasc. Disease + Failure												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from June 15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not attend, was consulted after death)												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
F.T. KASIK, JR.		M.D.				7/12/79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
F.T. KASIK, JR. M.D.		9005 HARFORD Rd Baltimore MD 21234										
23a. BURIAL CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
BURIAL		7-16-79		SAC. HEART CEM		BALTIMORE MD						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Raymond L. Kaczorowski		2525 FLEET ST.		JUL 16 1979		R. K. Brady						

1892

Handwritten notes and calculations, including a large 'X' and various numbers.

Handwritten notes and calculations, including a large 'X' and various numbers.

Handwritten notes and calculations, including a large 'X' and various numbers.

Handwritten notes and calculations, including a large 'X' and various numbers.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

79 16486

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		07		17 79 11:17P M	
CHRISTOPHER		SCOTT		WOOD							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		MONTH DAY YEAR		07 17 79		MONTHS DAYS		HOURS MIN	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U.S.				BALTIMORE COUNTY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY					
TOWSON		GREATER BALTIMORE MEDICAL CENTER		-		-					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		EDGWOOD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2015 MORGAN ST, 21040					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
WILLIAM ROBERT WOOD		SANDRA LEE BOWERS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		--		Hobert Scott Burton		Edgewood, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 7700		Bronchopneumonia & subarachnoid hemorrhage		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/17/1979, to 7/17/1979, that (I) (we) last saw the deceased alive on 7/17/1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
		Rudiger Breiteneker				7/ 19/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Rudiger Breiteneker, M.D.		6701 N. Charles St, Towson, Md. 21204									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		July 21, 1979		Cokesbury Mem. Cem.		Abingdon Harford Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME		ADDRESS		JUL 24 1979							
Howard K. McComas III, Abingdon, Md.											

0 0 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MATTIE MAE WOOD</b>			2b. DATE OF DEATH MONTH <b>July</b> DAY <b>3</b> YEAR <b>79</b>			2c. HOUR <b>5<sup>PM</sup></b>			
3. SEX <b>Female</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>13</b> YEAR <b>89</b>		6. AGE (IN YEARS) (AT BIRTH) <b>89</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (COUNTRY) <b>Ind</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Rossville</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Ind</b>		13b. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4015 Chesley Ave.</b>			
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Oliver</b> LAST <b>Nippard</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elosia</b> MIDDLE <b>C</b> LAST <b>Meise</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>220-46-9014</b>		17. INFORMANT ADDRESS <b>Dorothea E. Hatch 4015 Chesley Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pulmonary decompensation + Collapse</b> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO OR AS A CONSEQUENCE OF <b>Hypertensive Arteriosclerotic Cardiovascular Dis.</b> DUE TO OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 79</b> to <b>July 19 79</b> , that (I) (we) lost <b>June 19 79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, I did not view the body after death.)									
22b. SIGNATURE <b>Frank Kasik</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>7/3/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK T. KASIK JR MD</b>						22e. ADDRESS <b>9005 Norfolk Rd. Baltimore</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b> ADDRESS <b>7401 Belair Road</b>						25. DATE RECEIVED BY REGISTRAR <b>JUL 9 1979</b> REGISTRAR'S SIGNATURE			



1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001

1001



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					7 9 1 6 4 8 8 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) RUTH ALICE WOOD					2a DATE OF DEATH MONTH DAY YEAR July 3, 1979			2b HOUR 6:35 P.M.	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR June 3, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Balto 13c CITY OR TOWN Rodgers Forge					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 81 Mufdock Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST WM. H Nicholas					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Brownfield				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. 219 20 5439		17 INFORMANT ADDRESS Anne Snedaker White Plains, N.Y.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4292 } DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cholelithiasis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several days	
								Years	
MEDICAL CERTIFICATION									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 24, 1979, to July 3, 1979, that (I) (we) lost saw the deceased alive on July 3, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Margaret L. Dobson						22c. DATE SIGNED 7/4/79		22d. ADDRESS 6701 N. Charles St., Balto., Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/6/1979		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cent.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Rd.					25a. DATE REC'D. BY REGISTRAR JUL 5 1970		25b. REGISTRAR'S SIGNATURE [Signature]		



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

16489

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Shirley Margaret Wright		2a. DATE OF DEATH MONTH DAY YEAR 7/10/79		2b. HOUR 12:10P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 10, 1938	
6 AGE (IN YEARS LAST BIRTHDAY) 40		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County		MD	
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC, 6701 N. Charles St. 21204		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Data Processing	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Md.		13b. COUNTY Baltimore	
13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5530 Bucknell Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST Harry F. Wright		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred A. Rupperecht			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 212-36-3163		17 INFORMANT ADDRESS Mr. Harry F. Wright same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio pulmonary arrest 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung disease DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Breast APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 6/29/79, 19, to 7/10/79, 19, that (I) (we) lost the deceased alive on 7/10/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.			
22b. SIGNATURE J. Arturo Fridman, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Arturo Fridman, M.D.		22e. ADDRESS GBMC, 6701 N. Charles Street 21204			

MEDICAL CERTIFICATION

29

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Leonard O. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 12 1979		25b. REGISTRAR'S SIGNATURE F. J. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*Handwritten signature or mark.*

*over 100*

*to be used for*

*the purpose of*

*Label*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 16490	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) LOUIS William WYBLE				2a. DATE OF DEATH July 29, 1979				2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 30, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Carney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 2422 Bradford Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Postal Worker			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Carney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2422 Bradford Rd. 21234			
14. FATHER'S NAME William Wyble				15. MOTHER'S MAIDEN NAME Amelia Denhardt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-10-4175		17. INFORMANT ADDRESS Mrs. Gertrude M. Wyble Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis to liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Louis J. Pratt, Jr., M.D.</i>				DEGREE M.D.				22c. DATE SIGNED 7/30/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis J. Pratt, Jr., M.D.				22e. ADDRESS 8402 Greenway Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 1, 1979		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR JUL 31 1979		25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>			

12

271-2-015



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 6 July 1979		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Dora			B.		Yingling	6/17/79		7	17	79	8:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 74 HRS	
Female		Caucasian		4 11 1891		88		MONTHS		DAYS	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY	
Maryland		U. S. A.				Baltimore County		Housekeeper		at Home	
15. CITY OR TOWN OF DEATH		16. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18. 13a. CITY OR TOWN		19. 13b. INSIDE CITY LIMITS?		20. 13c. STREET ADDRESS	
Baltimore		Valley View Nursing Home		Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2523 Creighton Avenue, 21234	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS	
William		Louisa		No		215-01-6374		Tam. Ly		Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) — Dehydration											
4280 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } Colagative heart Failure											
DUE TO, OR AS A CONSEQUENCE OF											
— Organic Brain Ed.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 6/15/78 to 7/17/78, that (I) (we) lost the deceased alive on 7/16/78, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Vuong Nguyen						7/18/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Vuong Nguyen		6 Linlow Ct Towson Md 21204		BURIAL		7/20/79		Lorraine		Baltimore Md	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. NAME OF CEMETERY OR CREMATORY		26b. DATE		26c. LOCATION	
Evans Funeral Chapel 8500 Harford Rd		JUL 20 1979		Richard M. Brady		Lorraine		JUL 20 1979		Baltimore Md	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 16492									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
MARIE E. YOUNGHEIM								7-8-79		10:30 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
FEMALE		WHITE		2-6-1910		69					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				BALTIMORE COUNTY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
CATONSVILLE		FOREST HAVEN						Weaver		Sewing Factory	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c INSIDE CITY LIMITS?		13d STREET ADDRESS					
Md		Anne Arundel		Baltimore		1528 Williams Street					
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Harry Edward		Minnie May Wyeth									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
NO		217-16-5923		John F. Youngheim		7706 Russell Avenue Pasadena, Md. 21222					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION 2500 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF } (c) Diabetes										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from Nov 1977, to 7-8, 1979, that (I) (we) lost saw the deceased alive on 7-8, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE HAROLD B. BROT		22c. DATE SIGNED 7-10-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD B. BROT							
22e ADDRESS 7220 Park Heights											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		July 12, 1979		Cedar Hill Cemetery		Baltimore Maryland					
24 FUNERAL DIRECTOR NAME		25a. DATE REG'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
McGully Funeral Home of Brooklyn Baltimore, Md. 21225		JUL 12 1979		[Signature]							

